COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

OWEN ELECTRIC COOPERATIVE, INC.	)	
	)	
_____	)	
	)	CASE NO. 96-372
ALLEGED VIOLATION OF COMMISSION REGULATIONS 807 KAR 5:006 AND 807 KAR 5:041	)	

O R D E R

Owen Electric Cooperative, Inc. ("Owen Electric"), a Kentucky corporation which engages in the distribution of electricity to the public for compensation for lights, heat, power, and other uses, and which was formed under KRS 279.010 to 279.220, is a utility subject to Commission jurisdiction. KRS 278.010; KRS 279.210.

KRS 278.280(2) directs the Commission to prescribe rules and regulations for the performance of services by utilities. Pursuant to this statutory directive, the Commission promulgated 807 KAR 5:041, Section 3, which requires electric utilities to maintain their plant and facilities in accordance with the standards of the National Electrical Safety Code (1990 Edition) ("NESC"). The Commission has also promulgated 807 KAR 5:006, Section 24, which requires each utility to adopt and execute a safety program. Owen Electric has executed such a safety program, and has adopted the "Safety Manual for an Electric Utility" as produced by the American Public Power Association as its safety manual.

Commission Staff has submitted to the Commission a Utility Accident Investigation Report dated April 26, 1996, appended hereto, which alleges:

1. On March 25, 1996, Argust Nelson Popham, a Service Technician for Owen Electric, was injured while attempting to repair a 7,200 Volt overhead hot line jumper. Mr. Popham was not wearing rubber gloves at the time of the accident. The injuries incurred by Mr. Popham were burns to both hands.

2. At the time of the incident, Mr. Popham was an employee of Owen Electric acting within the scope of his employment.

3. Mr. Popham's failure to wear his rubber gloves while working on the line jumper represents a probable violation by Owen Electric of NESC, Section 42, Subparagraph 420H., Tools and Protective Equipment, which requires employees to use the personal protective equipment, the protective devices, and the special tools provided for their work.

Furthermore, Owen Electric's Safety Manual, Section 6, paragraph 602, Flexible Protective Equipment, states that:

> a) Employees shall not touch or work on any exposed energized lines or apparatus except when wearing protective equipment approved for the voltage to be contacted.
>
> b) When work is to be done on or near energized lines, all energized and grounded conductors or guy wires within reach of any part of the body while working shall be covered with rubber protective equipment, except that part of the conductor on which the employee is to work.
>
> f) Protective equipment shall be put on before entering the working area within which energized line or apparatus may be reached and shall not be removed until the employee is completely out of reach of this area.

Paragraph 604, Use and Care of Rubber Gloves, states that:

> c) Rubber gloves are recommended to be worn while working on any pole or other structure on which energized lines

> or equipment are located, on which lines and equipment that could be energized are located, or that are located close to energized lines or equipment where an employee could make contact. The rubber gloves should be put on before the employee ascends a pole or structure or raises an aerial device off the ground or device's cradle. Furthermore, employees should not remove the gloves until they have descended the pole or structure or returned the aerial device to the ground or cradle. As a minimum requirement, gloves should be put on before the employee comes within falling or reaching distance (in any event not less than 5 feet) of unprotected energized circuits or apparatus or those which may become energized, and they shall not be removed until the employee is entirely out of falling or reaching distance of such circuits or apparatus.
>
> d) [R]ubber gloves shall be worn during the following conditions:
>
> 1) Working on or within falling or reaching distance of conductors, electrical equipment, or metal surface (crossarms, crossarm braces, or transformer cases), which are not effectively grounded and which may be or may become energized.
>
> 12) Pulling in wires or handling other conducting materials near circuits, apparatus, or equipment that is or may become energized.

Thus, Mr. Popham's failure to wear his rubber gloves while working on the line jumper is a violation of Owen Electric's safety manual, which in turn represents a failure in Owen Electric's safety program.

Based on its review of the Utility Accident Investigation Report, and being otherwise sufficiently advised, the Commission finds that prima facie evidence exists that as a result of Mr. Popham's failure to wear his protective rubber gloves, Owen Electric is in probable violation of 807 KAR 5:006, Section 24, and 807 KAR 5:041, Section 3.

The Commission, on its own motion, HEREBY ORDERS that:

1. Owen Electric shall submit to the Commission, within 20 days of the date of this Order, a written response to the allegations contained in the Utility Accident Investigation Report and this Order.

2. Owen Electric shall appear before the Commission on October 1, 1996, at 10:00 a.m., Eastern Daylight Time, in Hearing Room 1 of the Commission's offices at 730 Schenkel Lane, Frankfort, Kentucky, for the purpose of presenting evidence concerning the alleged violations of 807 KAR 5:006, Section 24, and 807 KAR 5:041, Section 3, and of showing cause why it should not be subject to the penalties prescribed in KRS 278.990(1) for its alleged failure to comply with Commission regulations.

3. The Utility Accident Investigation Report of April 26, 1996, a copy of which is appended hereto, is hereby made a part of the record of this proceeding.

4. Any motion requesting an informal conference with Commission Staff to consider any matter which would aid in the handling or disposition of this proceeding shall be filed with the Commission no later than 20 days from the date of this Order.

Done at Frankfort, Kentucky, this 13th day of August, 1996.

PUBLIC SERVICE COMMISSION

Linda K Breathitt
Chairman

Vice Chairman

ATTEST:

Don Mills
Executive Director

Robert M. Davis
Commissioner

APPENDIX A

AN APPENDIX TO AN ORDER OF THE KENTUCKY PUBLIC SERVICE COMMISSION IN CASE NO. 96-372 DATED AUGUST 13, 1996

UTILITY ACCIDENT INVESTIGATION REPORT

Utility:	Owen Electric Cooperative				
Reported By:	Danny Stockdale - Owen Electric Cooperative				
Dates & Times					
Accident Occurred:	03/25/96 - Approximately 2:45 pm				
Utility Notified:	03/25/96 - Approximately 2:45 pm				
PSC Notified:	03/25/96 - 3:03 pm				
Investigated:	03/26/96				
Written Report Rcvd:	03/26/96				
Location of Accident:	1304 Stephenson Mill Road, Boone County, Walton, Kentucky				
Description of Accident:	Argust Nelson Popham, a Service Technician for Owen Electric Cooperative, was injured while attempting to repair a 7,200 Volt overhead hot line jumper. Mr. Popham was not wearing his rubber gloves at the time of the incident.				
Victims:					
Name:	Argust Nelson Popham	**Fatal:**	No	**Age:**	56
Addr./Empl.:	510 South Main Street, Owenton, KY/Owen Electric Cooperative				
Injuries:	Burns to both hands.				
Witnesses:	**Name**	**Address/Employment**			
	None				
Sources of Information:	**Name**	**Address/Employment**			
	Danny Stockdale	510 South Main Street, Owen, KY/Owen Electric Cooperative			
	Bill Smith	510 South Main Street, Owen, KY/Owen Electric Cooperative			
	John W. Land	PSC Engineering Staff on site investigation			
Probable Violations:	1990 NESC, Rule 420 H				

Line Clearances At Point of Accident:	Measured	Minimum Allowed by NESC	Applicable NESC Edition[1]	Volt.	Constr. Date
Primary Phase to Ground Elevation (F):	31' - 10"	18' - 6"	1990, Table 232-1	7200 V	Approx. 1950 Pole Date
Primary Neutral to Ground Elevation:	28' - 1"	15' - 6"	1990, Table 232-1	N/A	"
Primary Phase to Ground Elevation:	33' - 10"	18' - 6"	1990, Table 232-1	7200 V	"
Primary Neutral to Ground Elevation:	29' - 8"	15' - 6"	1990, Table 232-1	N/A	"
Primary Phase to Ground Elevation:	34' - 0"	18' - 6"	1990, Table 232-1	7200 V	"
Primary Neutral to Ground Elevation:	30' - 0"	15' - 6"	1990, Table 232-1	N/A	"
Date of Measurement:	03/26/96				
Approximate Temp.:	35°				
Measurements Made By:	Danny Stockdale and Bill Smith, Owen Electric Cooperative and John W. Land, PSC Engineering Staff				
Investigated By:	John W. Land				
Signed:	John W. Land				

[1] Current edition adopted by the Commission. If clearances are not in compliance with the current edition, then the edition in effect when the facilities were last constructed or modified would apply.

Attachments:

A. PSC Accident Report Form
B. Owen Electric Cooperative's Accident Investigation
C. Photographs

Attachment A

PSC Accident Report Form

P. S. C.
ACCIDENT AND TROUBLE REPORT FORM

TODAY'S DATE 3-25-96 TIME 3:03 P.M.

COMPANY Owen Electric Cooperative

PERSON REPORTING INCIDENT: NAME: Danny Stockdale

TITLE:

ADDRESS: 510 S. Main St. Owenton, Ky 40359

PHONE NO: (502) 484-3471

ACCIDENT DESCRIPTION: Employee Contact

VICTIMS NAMES: Nelson Popham SEX M AGE 56 DEATH ___ INJURY ✓

SEX ___ AGE ___ DEATH ___ INJURY ___

SEX ___ AGE ___ DEATH ___ INJURY ___

LOCATION OF ACCIDENT: Walton, Ky (Boone Co.)

TIME OF OCCURRENCE: Approx: 2:45

TROUBLE DESCRIPTION: N/A

TIME OF OCCURRENCE: N/A

TIME OF RESUMPTION OF NORMAL SERVICE: N/A

NUMBER OF CUSTOMERS AFFECTED: N/A

SIGNED John W Land

DATE 3-25-96

Attachment B

Owen Electric Cooperative's Accident Investigation

OWEN ELECTRIC COOPERATIVE

510 South Main Street • P.O. Box 400 • Owenton, Kentucky 40359-1261 • 502/484-3471

April 4, 1996

Mr. John Land
Public Service Commission
730 Schenkel Lane
Frankfort, KY 40601

Dear Mr. Land:

Enclosed you will find our final accident investigation report for the March 25, 1996 accident involving Mr. Nelson Popham. I have also included a copy of the photos I took the day of the accident, as well as, the information you requested on our last system inspection. It appears that the line was constructed in 1950.

We have confirmed our investigation and have discovered some additional information which helps clarify what happened. I have included a copy of the service order Mr. Popham was working just prior to the accident.

Mr. Popham went to 1304 Stephenson Mill Road to remove the meter from an account that had been disconnected since August, 1994. When attempting to disconnect the transformer, he discovered a primary line jumper had fallen out of the hot line clamp. He radioed the dispatcher to check if she had received any outage calls and notified her of his plan to repair the jumper. Mr. Popham proceeded to climb the transformer pole and disconnect the transformer jumper. He recalls having one hand on the transformer, the location of other hand is unknown, and seeing a flash. The next thing he remembers is being upside down on the pole.

The day after your investigation, we retrieved the wedge clamp which supported the service wire and found it had several marks indicating contact with the loose jumper. It appears that the flash Mr. Popham saw was the jumper arcing on the wedge clamp, thereby energizing the service wire. Mr. Popham's other hand was in contact with either the service wire or some equpment attached to the service wire, thereby causing current to flow between his hands. The fact that the service wire was a better path to ground than his body is the only reason his injuries were not more severe.

The proper use of the personal protective equipment provided would have prevented the accident from happening and the fact that this equipment was not used is a direct violation of OEC's safety rules as well as a violation of the NESC.

In accordance with our union contract with the IBEW, a safety committee will meet to review the accident and impose any disciplinary action deemed necessary.

If you have need any additional information , feel free to contact me anytime.

Yours truly,

OWEN ELECTRIC COOPERATIVE

Danny Stockdale
VP Construction and Maintenance

DS:trb

Enclosures

Received 3/26/96
Jack

- PRELIMINARY REPORT-

ACCIDENT INVESTIGATION FORM

Report prepared 3/26/96

DATE 3/25/96 (Date of Accident) COMPLETED BY Bill Smith

LOCATION/ADDRESS 1304 Stephenson Mill Rd., Walton, KY

Time of Accident: 2:45 PM (Approximate)

NAME OF INJURED Argust Nelson Popham S.S.# 403-56-3395

TITLE Serviceman DATE OF BIRTH 2-1-40

MALE X FEMALE

YEARS OF EXPERIENCE AT PRESENT JOB

DATE OF ACCIDENT 3/25/96 TIME OF ACCIDENT 2:45 PM

NATURE OF INJURY Electrical contact burns - both hands

WAS FIRST AID GIVEN? X YES NO

WAS A DOCTOR SEEN? X YES NO

DOCTOR'S NAME St. Luke West Hospital Emergency Room, 7380 Turfway Rd, Florence
Transferred to University of Cincinnati Hospital, Goodman Ave., Cincinnati, OH

WITNESSES: (Addresses & phone numbers) none

NATURE OF ACCIDENT Employee was working on pole (diagram attached)

Employee experienced electrical contact - saw a flash, does not remember how accident occurred - Further information will be available as employee improves. We will inquire as soon as employee is able to discuss situation.

(Upon observation by investigating staff, an energized jumper wire was hanging down because it had come loose from the hot line clamp. The jumper wire was dangling near the pole where the accident occurred. (See diagram) - This may or may not have been a factor.)

LINE INSPECTION AND MAINTENANCE LOG SHEET

	POLE OR STATION NO.	OVERHEAD: POLE: TREATER & BRAND YEAR	POLE: LENGTH & CLASS	POLE: REPLACE	POLE: REINSPECT	POLE: RESET	POLE: NOTE	GUY-ANCHOR: ADD GUARD	GUY-ANCHOR: REPAIR	GUY-ANCHOR: REPLACE	GRD. ROD: INSTALL	GRD. ROD: REPAIR	CROSSARM (NOTE)	INSU-LATOR: PIN TYPE	INSU-LATOR: SUSPENSION	INSU-LATOR: SEC-SERVICE	CONDUCTOR: RESAG: LINE COND	CONDUCTOR: RESAG: UNDERBUILD	CONDUCTOR: RESAG: SERVICE	CONDUCTOR: OTHR: REPAIR	CONDUCTOR: OTHR: RETIE	RIGHT OF WAY: CLEAR OR TRIM	RIGHT OF WAY: DANGER TREE	RIGHT OF WAY: DANGER OTHER	OTHER: TRANSFORMER	OTHER: OTHER EQUIP	OTHER: LONG SECNDRY	OTHER: HARDWARE	OTHER: RADIO NOISE	OTHER: ATTACHMENTS	OTHER: CLEARANCES	UNDERGROUND: PAD-MOUNT: SAFETY	PAD-MOUNT: REPAIR	PAD-MOUNT: LEVEL	PAD-MOUNT: CONNECTIONS	VAULT: CLEAN/FLUSH	VAULT: REPAIR	VAULT: FILL-LEVEL	VAULT: REPOSITION LEAD	RIGHT OF WAY: CONFLICT	RIGHT OF WAY: LEVEL-FILL	RISER CABLE: GUARD	RISER CABLE: SUPPORT	RISER CABLE: RE-POSITION	RISER CABLE: GALV. GROUND. ROD	NOTES
D M	439-13-16																								✓																				S/L Burning
D E	453-20-25				✓																																							A-5 Bad Top
D M	453-23-57														✓																														Broken Bell 10" Glass
D R/W	439-17																					✓																							Trim Yard Trees in Subdivision
	439-23																					✓																							
D R/W	348-02-36																					✓																							Trim Pine Tree
D E	348-14-28																																											Inactive Account 2 spans 6-A
	07-92																																										
R/W	347-12-68																						✓																							Cut 3 Dead Trees
	362-13-55																																											Inactive Account
R/W	362-07-55																																												Inactive Account
D E	362-02-03																									✓																				C/O L-Arrester on Transform
D R/W	362-03-47																						✓																							Trim Yard Tree
	INSPECTOR R.H.																																											
	DATE 2/7/94																																											
	ALL WORK COMPLETED																																											

9.4 air Patrol

MAINTENANCE ORDER

NAME: _____ ADDRESS: _____

COUNTY: ~~Boo~~ Hinton / Bound DATE: 2/16/94 RECEIVED BY: _____

Stem 4 - Imm Yard Tree in Subdivision 439-17 SYLVAN DR 439-23 Sylvan Dr
Completed 2/23/94
Henry Hovelsen

5 - Imm Pine Tree 348-02-36 Old Salem Creek Rd
Done 4/5/94

7 - cut (2) Dead Trees 347-17-68 16 Bellamy St Walk! 362-13-99 Stephenson
Done 4/4/94

8 - cut Dead Tree 362-07-55 Stephenson Mill Road
Done 4/4/94 Willie Cook

10 - Imm Yard Tree 362-03-47 Pennington Lane
Done 4/4/94 Willie Cook

Final Report

ACCIDENT INVESTIGATION FORM

Report prepared 3/26/96

DATE 3/25/96 (Date of Accident) COMPLETED BY Bill Smith

LOCATION/ADDRESS 1304 Stephenson Mill Rd., Walton, KY

Time of Accident: 2:45 PM (Approximate)

NAME OF INJURED Argust Nelson Popham S.S.# 403-56-3395

TITLE Serviceman DATE OF BIRTH 2-1-40

MALE X FEMALE ____

YEARS OF EXPERIENCE AT PRESENT JOB 18 years

DATE OF ACCIDENT 3/25/96 TIME OF ACCIDENT 2:45 PM

NATURE OF INJURY Electrical contact burns - both hands

SEE ATTACHED LETTER OF EXPLANATION

WAS FIRST AID GIVEN? X YES ____ NO

WAS A DOCTOR SEEN? X YES ____ NO

DOCTOR'S NAME St. Luke West Hospital Emergency Room, 7380 Turfway Rd, Florence
Transferred to University of Cincinnati Hospital, Goodman Ave., Cincinnati, OH

WITNESSES: (Addresses & phone numbers) none

NATURE OF ACCIDENT Employee was working on pole (diagram attached)

Employee experienced electrical contact - saw a flash, does not remember how accident occurred - Further information will be available as employee improves. We will inquire as soon as employee is able to discuss situation.

(Upon observation by investigating staff, an energized jumper wire was hanging down because it had come loose from the hot line clamp. The jumper wire was dangling near the pole where the accident occurred. (See diagram) - This may or may not have been a factor.)

OWEN ELECTRIC COOPERATIVE

510 South Main Street • Owenton, Kentucky, 40359 • 502/484-3471

SO NO 151415 DIST 11

REQ BY RODNEY

TAKEN BY MARY ELLEN 03/13/96

APL. NO 09:24

OWEN PRINTED ** 01 ** TIMES

ESC MISCELLANEOUS MAINT. WORK ON 03/13/96

'EPHENSON RICKEY L
:LLY BELINDA J
304 STEPHENSON MILL RD
ALTON KY

41094-9575
ONPUBLISHED PHONE

MBRSEP 34943-01
SS NO 405-82-1912
S-SS NO
TEL 6064857827
B PHONE
DRV LIC
S BUS NO

CYC	99	RATE	1	TAX CD	N
TDC	61	CLASS	30	ASST	N
DST	OWEN	PRI		BUD	
COU	6	NEWS	Y	AMT	
CTY		PEN	N	DTE	
BCD	4	CUT	N	SVC	
NEB		MAIL	Y	MIN	

FEES — DEPOSITS / CHARGES

	BILL	APPLY	PD	EXIST		CD	CHARGE
E					MISC		
P					OTH		
H							

LOCATION DATA

C	61362073293	CYC 308	SUB	4	UG	STEPHENSON RICKEY L	
Q	308000027500		CIR	6	HC	C-DTE	12/13/91
C	1304 STEPHENSON MILL RD		BKR		AC	D-DTE	08/25/94
E			PHA	1	MH	1 SO REF	
D	R LANE WHITE TRAILER MP		HP		SW		
A	61362074263				LS	6018	TEN

SECURITY LIGHT DATA

	CONSUMER RATE	TY	NO	KWH	AMOUNT		LOCATION RATE	TY	NO	KWH	AMOUNT
	1	1	1			1)	1	1	1		
						2)					
						3)					
						4)					

METER DATA

RATIO: 01 TY: MS RDG 02675

	DATE	COOP NO	VOLTS	AMP	WIRE	MUL	DL	DM	IC	READ	DEMAND
JT		51527 MFG: 5 PH: 1	240	30.0	3	1	5		1	02675	

ARY ELLEN WED. MAR 13. 1996. 9:23 AM

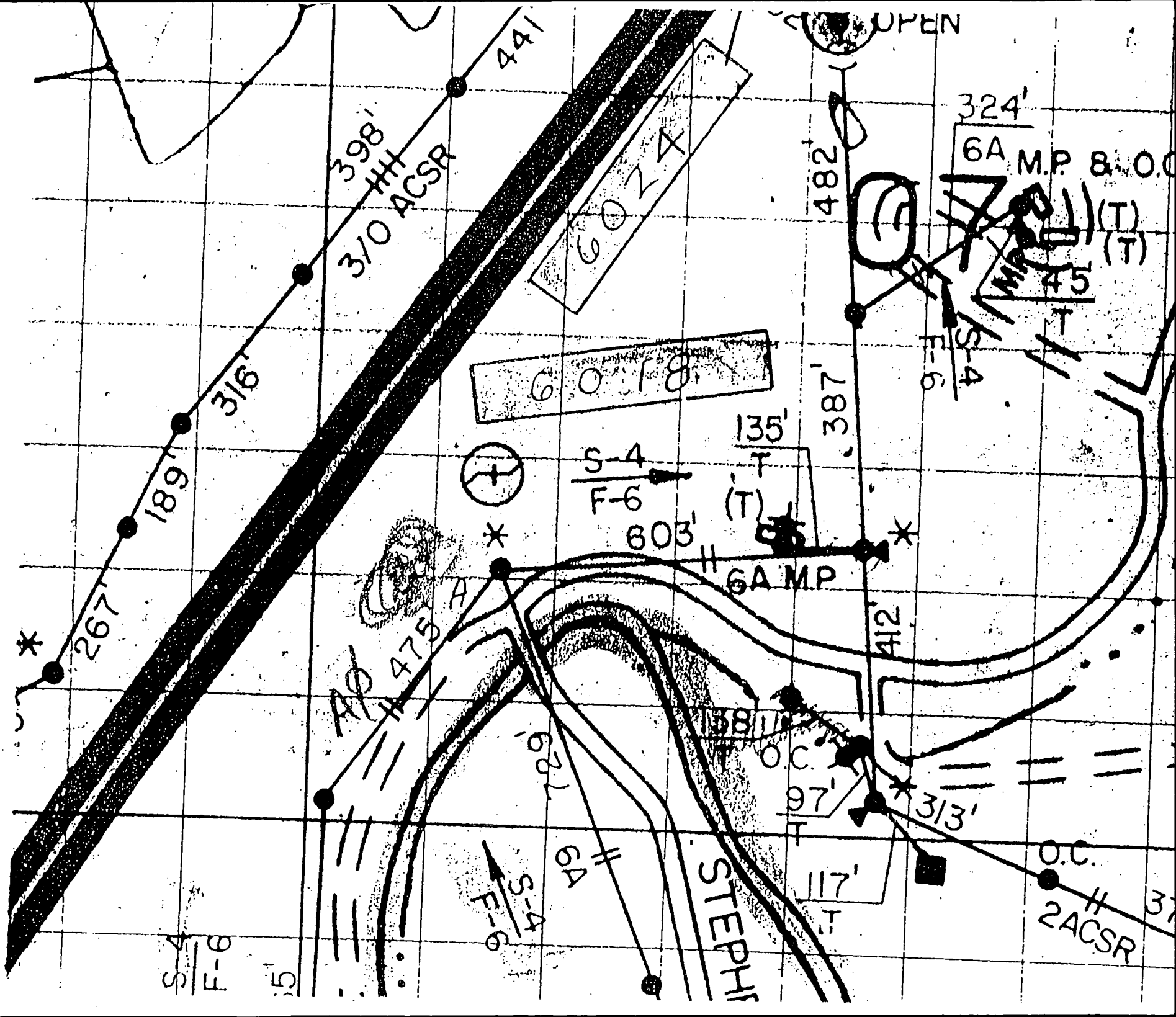
TER D/C 8/94. PLEASE REMOVE METER. INSTALL COVER. D/C AT TRANSF.
POSSIBLE.

Steel mill Rd.

Dr, nt To Stock

SNED-SERVICEMAN AMP DATE WORKED 3-25-96 PROCESSED BY

W SERVICE ROUTING Construction Engineering Drafting Loc. File


OPEN
324'
6A M.P. & O.C.
(T)
(T)
482'
441'
398'
3/0 ACSR
6024
6018
316'
189'
267'
135'
T
387'
S-4
F-6
(T)
603'
6A M.P.
412'
475'
A
138'
T
O.C.
97'
T
313'
O.C.
117'
T
2ACSR
STEPH

FORM NO. S. F. 1
(REV. 1964)

EMPLOYER'S FIRST REPORT OF INJURY

Department of Labor, Workmen's Compensation Board
Frankfort, Kentucky 40601

KRS 342.990 authorizes ... ie for employer's refusal or willful neglect to submit this report within one week of knowledge of injury. To comply with this regulation, each question must be answered legibly, accurately, and completely. Improperly prepared reports may be refused and returned. Please use typewriter, or print. If a question "does not apply" to your case, mark DNA. See instructions on back of page.

NAME OF WORKMEN'S COMPENSATION INSURANCE COMPANY.....

EMPLOYER

Policy Number: 33 WCP 380 294

Name..... (Give name under which concern does business)

Mail address..... (No. and Street) (City or Town) (State) Phone.....

Nature of business..... (Manufacturing shoes, retailing men's clothes, trucking for hire, etc.)

INJURED EMPLOYEE

Name ARGUST (First Name) NELSON (Middle Name) POPHAM (Last Name) 5. Social Security No. 403-56-3395

Home address 21 BEDINGER AVE. (No. and Street) WALTON (City or Town), KY (State) 41094

Age 32 8. Sex: Male X Female (Check One) 9. Marital status: Married X Single (Check One)

Occupation (job title) LINEMAN 11. Department.....

Number months employed by you 45 mo.

No. of hours worked per day 8; per week 40 14. No. of days worked per week 5

Wages: $ 4.64 per hour; or $ 37.12 per day; or $ 185.60 per week. 16. If paid on other than a time basis, such as piece work or commission, enter actual average weekly earnings during last..... weeks: $..... per week.

If board, lodging, or other advantages were furnished in addition to wages, state estimated weekly value: $ 0 per week.

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL DISEASE

Place of accident or exposure TOM KELLY (Number and Street) RESIDENCE (City or Town) BOONE (County) - 19. Was it on employer's premises?.....

What was the employee doing when injured? ON POLE PULLING WIRE ONTO (Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.) INSULATOR'S

How did the accident occur? SAME AS ABOVE, FELT PAIN IN BACK (Describe fully the events which resulted in the injury or occupational disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

INJURY OR OCCUPATIONAL DISEASE

Describe the injury or disease in detail and indicate the part of body affected BACK - LOWER TOP (e.g.: amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, pushing, etc.) PULLING WIRE

Date of injury or occupational disease: 1/12/73 (Date) 25. Hour of day 3 a.m. p.m. 26. Was employee paid in full for this day? yes

Was employee unable to work because of the injury or disease on any day after the day of injury (including Sunday or any other day on which he would not usually work)? yes 1-13-73 1-19-73 Still off since 1/24/73 28. If yes, give date last worked: Date: 1-24-73

Has employee returned to work? no 30. If yes, give date: ..... 31. At what wage? $..... per hour; or $..... per day; or $..... per week.

Did employee die? Yes..... No X (Check One) 33. If yes, give date of death....., and name and address of nearest relative.

Name and address of physician MANFRED E KRAUSE MD 71 E. HOLLISTER ST. CIN. O

If hospitalized, name and address of hospital GOOD SAMARITAN FOR X RAYS CIN, O

1-31-73 (Date of Report) Dept. Claims Supervisor (Prepared by) (Official Position)

DO NOT WRITE IN THIS COLUMN

File No.
Carrier No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Months on Job
Weekly Wage
County of Injury
Nature of Injury
Part of Body
Accident Type
Source of Injury
Agency of Accident
Extent of Disability
Injury Date
Hour of Injury
Disability Date
Report Date

EMPLOYER'S FIRST REPORT OF INJURY

Department of Labor, Workmen's Compensation Board
Frankfort, Kentucky 40601

KRS 342.990 Penalties ... fine for employer's refusal ... Must submit this report within one week of knowledge or injury ... To comply with this regulation, each question must be answered legibly, accurately and completely. Improperly prepared reports may be refused and returned. Please use typewriter, or print. If a question "does not apply" to your case, mark DNA. See instructions on back of page.

NAME OF WORKMEN'S COMPENSATION INSURANCE COMPANY .....

EMPLOYER

Policy Number

1. Name Owen County Rural Electric Cooperative Corp. (Give name under which concern does business)
2. Mail address 330 Brighstown Rd. (No. and Street) Owenton (City or Town) Ky. (State) Phone 484-3471
3. Nature of business Distribution of Electricity (Manufacturing shoes, retailing men's clothes, trucking (or hire, etc.)

INJURED EMPLOYEE

4. Name Robert Allen Perkins (First Name) (Middle Name) (Last Name) 5. Social Security No. 403 56 3555
6. Home address 21 Bonner Ave, (No. and Street) Warsaw (City or Town) Ky. (State) 41095
7. Age 37 8. Sex: Male X Female ... 9. Marital status: Married X Single ... (Check One)
10. Occupation (job title) Lineman 11. Department Const.
12. Number months employed by you 15 yrs
13. No. of hours worked per day 8; per week 40 14. No. of days worked per week 5
15. Wages: $ 7.01 per hour; or $ ... per day; or $ ... per week. 16. If paid on other than a time basis, such as piece work or commission, enter actual average weekly earnings during last ... weeks: $ ... per week.
17. If board, lodging, or other advantages were furnished in addition to wages, state estimated weekly value: $ ... per week.

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL DISEASE

18. Place of accident or exposure Union & Hathaway Rd. (Number and Street) Boone (City or Town) (County) 19. Was it on employer's premises? No
20. What was the employee doing when injured? Trimming trees - let self down with rope tied to climbing belt - sudden stop, hurt back (Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.)
21. How did the accident occur? Coming down out of tree (Describe fully the events which resulted in the injury or occupational disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

INJURY OR OCCUPATIONAL DISEASE

22. Describe the injury or disease in detail and indicate the part of body affected. Lower Back (e.g.: amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)
23. Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, pushing, etc.) Rope tied onto body belt coming down out of tree, stopped suddenly, hurt lower back
24. Date of injury or occupational disease 5-6-77 (Date) 25. Hour of day 3 a.m. (p.m.) 26. Was employee paid in full for this day? yes
27. Was employee unable to work because of the injury or disease on any day after the day of injury (including Sunday or any other day on which he would not usually work)? yes 28. If yes, give date last worked: Date: 5-6-77
29. Has employee returned to work? No 30. If yes, give date: ... 31. At what wage? $ ... per hour; or $ ... per day; or $ 245 per week.
32. Did employee die? Yes ... No X (Check One) 33. If yes, give date of death ... and name and address of nearest relative.
34. Name and address of physician Dr. J. ... Owenton ... Ky.
35. If hospitalized, name and address of hospital DNA

5-9-77 (Date of Report)
Dr. Webster (Prepared by)
Supt.

DO NOT WRITE IN THIS COLUMN

File No.
Carrier No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Months on Job
Weekly Wage
County of Injury
Nature of Injury
Part of Body
Accident Type
Source of Injury
Agency of Accident
Extent of Disability
Injury Date
Hour of Injury
Disability Date
Report Date

Form LCO884-1 Printed ...

State's Number Fed: ..... Carrier ..... Employer .....

Carrier's File No. .....

(The spaces above not to be filled in by employer)

Policy Sym. & No. .....

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Employer

1. Name of Employer Ohio Valley REC
2. Office address: No. and St. 1329 Gate City Blvd City or Town Owensboro State Ky
3. Insured by Name of Company Owensboro City Ky Co
4. Nature of business (or article manufactured) Distribution of Electricity

Time and Place

5. (a) Location of plant or place where accident occurred ..... Department ..... State if employer operates .....
   (b) If injured in a mine, did accident occur on surface, underground, shaft drift or mill .....
6. Date of injury 4-19-77 19 77 Day of week Third day Hour of day 1 A. M. ..... P. M.
7. Date disability began ..... 19 ..... A. M. ..... P. M. 8. Was injured paid in full for this day .....
9. When did you or foreman first know of injury .....
10. Name of foreman Morgan Chandler

Injured Person

11. Name of Injured H Nelson Popham (First Name) (Middle Initial) (Last Name)
12. Address: No. and St. 21 Belanger Ave City or Town Walton State Ky
13. Check ( ) Married ✓, Single ....., Widowed ....., Widower ....., Divorced .....; Male ✓, Female .....
15. Age 37 Did you have on file employment certificate or permit No
16. (a) Occupation when injured Linemen (b) Was this his or her regular occupation Yes
    (If not state in what department or branch of work regularly employed) .....
17. (a) How long employed by you 14 (b) Piece or time worker ..... (c) Wages per hour $ 7.01
18. (a) No. hours worked per day 8 (b) Wages per day $ .....
    (c) No. days worked per week 40 (d) Average weekly earnings $ .....
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury No 20. Kind of power, (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation No
24. Describe fully how accident occurred, and state what employee was doing when injured Step off back of truck twisted left ankle
25. Names and addresses of witnesses Jim Cook

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left) Left ankle
27. Probable length of disability ..... 28. Has injured returned to work No
    If so, date and hour ..... At what wage $ .....
29. At what occupation Linemen
30. (a) Name and address of physician Dr Walter Main St Walton Ky
    (b) Name and address of hospital .....

Fatal Cases

31. Has injured died No If so, give date of death .....

Date of this report 5-2-77 Firm name Owen Co Rural Electric Co-op

Signed by Jim Walker Official Title Mgr

2047 UAC

EMPLOYER'S FIRST REPORT OF INJURY

partment of Labor, Workmen's Compensation Board
Frankfort, Kentucky 40601

with this regulation, each question must be answered legibly, accurately, and completely. Improperly prepared reports may be refused and returned. Please use typewriter, or print. If a question "does not apply" to your case, mark DNA. See instructions on back of page.

NAME OF WORKMEN'S COMPENSATION INSURANCE COMPANY.....

EMPLOYER

Name Owen County R.E.C.C. (Give name under which concern does business) Policy Number WC 9658958

Mail address 510 Georgetown Rd. (No. and Street) Owenton (City or Town) Ky. (State) 40359 Phone 502-484-3471

Nature of business Elec. Distribution (Manufacturing shoes, retailing men's clothes, trucking for hire, etc.)

INJURED EMPLOYEE

Name Aggist (First Name) Nelson (Middle Name) Pa Phan (Last Name) 5. Social Security No. 402-56-3395

Home address 21 Bedingerave (No. and Street) Walton (City or Town) Ky. (State)

Age 38 8. Sex: Male ✓ (Check One) Female ..... 9. Marital status: Married ✓ Single ..... (Check One)

Occupation (job title) Lineman 11. Department Construction

Number months employed by you 15 yrs

No. of hours worked per day 8; per week 40 14. No. of days worked per week 5

Wages: $7.83 per hour; or $..... per day; or $.....per week. 16. If paid on other than a time basis, such as piece work or commission, enter actual average weekly earnings during last.....weeks: $.....per week.

If board, lodging, or other advantages were furnished in addition to wages, state estimated weekly value: $.....per week.

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL DISEASE

Place of accident or exposure Colonial State Supervision Grone Co. (Number and Street) (City or Town) (County) 19. Was it on employer's premises?

What was the employee doing when injured? Setting Electric Pole (Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.)

How did the accident occur? Knee Twisted & unable to put Weight on (Describe fully the events which resulted in the injury or occupational disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

INJURY OR OCCUPATIONAL DISEASE

Describe the injury or disease in detail and indicate the part of body affected Knee (e.g.: amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, pushing, etc.) pushing pole in hole

Date of injury or occupational disease: 9-7-78 (Date) 25. Hour of day 2- a.m. p.m. 26. Was employee paid in full for this day? yes

Was employee unable to work because of the injury or disease on any day after the day of injury (including Sunday or any other day on which he would not usually work)? yes 28. If yes, give date last worked: Date: 9-8-78

Has employee returned to work? no 30. If yes, give date: ..... 31. At what wage? $.....per hour; or $..... per day; or $.....per week.

Did employee die? Yes.....No ✓ (Check One) 33. If yes, give date of death....., and name and address of nearest relative.

Name and address of physician MANFRED E. KRAUSE MD. 2415 AUBURN AVE. - Cin. O

If hospitalized, name and address of hospital.....

9/9/78 (Date of Report) Don Webster (Prepared by) Surgeon (Official Station)

DO NOT WRITE IN THIS COLUMN

File No.
Carrier No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Months on Job
Weekly Wage
County of Injury
Nature of Injury
Part of Body
Accident Type
Source of Injury
Agency of Accident
Extent of Disability
Injury Date
Hour of Injury
Disability Date
Report Date

FORM S F. 1 (REVISED JAN. 1977)
KENTUCKY DEPARTMENT OF LABOR
WORKMEN'S COMPENSATION BOARD
FRANKFORT, KY. 40601

This form fulfills the requirements for OSHA Form 101.

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS AND SUPPLEMENTARY RECORD UNDER THE OCCUPATIONAL SAFETY AND HEALTH ACT

IF THIS CASE WAS OSHA RECORDABLE, INDICATE REASON FOR RECORDING AND GIVE OSHA CASE OR FILE NUMBER

Restriction of work; Medical Treatment
Reason for recording (e.g. "loss of consciousness").

7
OSHA Case or File Number (from your OSHA Form 100)

KRS 342.990 AUTHORIZES A FINE FOR EMPLOYER'S REFUSAL OR WILLFUL NEGLECT TO SUBMIT THIS ORIGINAL REPORT, WITHIN ONE WEEK OF KNOWLEDGE OF INJURY, TO THE WORKMEN'S COMPENSATION BOARD. TO COMPLY WITH THIS LAW, EACH QUESTION SHALL BE ANSWERED COMPLETELY, ACCURATELY AND LEGIBLY. IMPROPERLY PREPARED REPORTS WILL BE REFUSED AND RETURNED. PLEASE USE TYPEWRITER OR PRINT IN INK. COMPLETE ALL QUESTIONS!

EMPLOYER

1. EMPLOYER'S NAME: Owen County R.E.C.C.
EMPLOYER NUMBER: 61-0299615
3. IF INDIVIDUAL OR PARTNERSHIP, NAME OF BUSINESS:
5. MAILING ADDRESS: 510 Georgetown Road
8. CITY / COUNTY / STATE / ZIP: Owenton, Kentucky 40359
10. WORKMEN'S COMPENSATION INSURANCE CARRIER: Home Insurance Co.
POLICY NUMBER: WC 9658958
(IF SELF INSURED, CHECK HERE ☐)

2. STREET OR ROAD LOCATION AT WHICH EMPLOYEE WORKED: 7353 Walton Nicholson Rd
4. CITY / COUNTY / STATE / ZIP: Independence, Ky 41051
6. AREA CODE-TELEPHONE: 502-484-3471
7. UNEMPLOYMENT INSURANCE I. D. NUMBER: 012321-6
9. NATURE OF BUSINESS (e.g., tree trimming, boot mfg.): electric distribution
11. SPECIFIC PRODUCT OR SERVICE COMPRISING MAJORITY OF SALES (e.g., ski boots): electricity sales

EMPLOYEE

12. EMPLOYEE'S NAME (FIRST / MIDDLE / LAST): Argust Nelson Popham
15. EMPLOYEE'S HOME ADDRESS: Bedinger Avenue
18. CITY / COUNTY / STATE / ZIP: Walton, Boone, Kentucky 41094

13. AREA CODE-TELEPHONE (HOME): 606-485-4641
14. SOCIAL SECURITY NUMBER: 403-56-3395
16. SINGLE ☐ MARRIED ☒ MALE ☐ FEMALE ☐
17. DATE OF BIRTH: 2-1-40
19. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Maintenance
20. REGULAR OCCUPATION (JOB TITLE): Lineman
21. DEPARTMENT WHERE WORKING WHEN INJURY OR ILLNESS OCCURRED: Maintenance
22. HOW LONG EMPLOYED BY YOU?: 15 years
23. HOW LONG IN PRESENT JOB?: 8 yrs.
24. NUMBER OF HOURS WORKED PER DAY: 8 PER WEEK:
25. NUMBER OF DAYS WORKED PER WEEK: 5
26. EMPLOYEE'S WAGE RATE $7.83 /HR; or $ /DAY; or $ /WK.
27. COMMISSION OR PIECE WORK EARNINGS $ IN HRS. IN PAST 12 MO.
28. WEEKLY DOLLAR VALUE OF PAY IN KIND (LODGING, FOOD, ETC.) $
29. NUMBER OF DEPENDENTS (Please complete back of form): 3
30. PLACE OF ACCIDENT OR EXPOSURE (LOCATION, INCLUDING COUNTY): Union-Hathaway Road, Boone County
31. DATE EMPLOYER NOTIFIED: 10-16-78

THE ACCIDENT OR EXPOSURE

32. ON EMPLOYER'S PREMISES? YES ☐ NO ☒
33. DATE OF OCCURRENCE: 10-16-78
34. TIME OF DAY: 2:00 PM
35. TIME WORKDAY BEGAN AND WOULD NORMALLY END FROM 8 (A.M.) TO 4:30 (P.M.)
36. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)
Employee was using a chain saw to trim a tree which fell on top of another tree causing second tree to split out and fall on victim's head.
37. (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)
The tree hit the victim on the forehead
38. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by; vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)
Tree

THE INJURY OR ILLNESS

39. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF BODY AFFECTED. (e.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)
Blow to forehead
FATAL? YES ☐ NO ☒
40. NAME AND ADDRESS OF TREATING PHYSICIAN: W.E. Reutman, M.D. Florence Medical Arts Center, Florence, Ky.
41. NAME AND ADDRESS OF HOSPITAL: IN PATIENT ☐ OUT PATIENT ☐
42. MEDICAL TREATMENT GIVEN (DESCRIBE): Examination & prescription
IF RESTRICTIONS OF DUTY OR PERMANENT TRANSFER TO ANOTHER JOB, CHECK ☐: restricted to light duty until 10/23
43. DATE STOPPED WORK BECAUSE OF THIS INJURY OR ILLNESS: 10-16-78
44. DATE RETURNED TO WORK: 10-19-78
45. NUMBER OF SCHEDULED WORK DAYS LOST TO DATE: 4
46. WAS EMPLOYEE PAID FOR FULL DAY ON DATE OF INJURY? YES ☒ NO ☐
47. IF DEATH, GIVE NAME AND ADDRESS OF NEXT OF KIN:
48. DATE OF DEATH:

49. REPORT PREPARED BY: Donna McDonald
50. TITLE: Insurance Admr.
51. DATE OF THIS REPORT: 10/19/78

DO NOT WRITE IN THIS COLUMN
File No.
Employer No.
U. I. No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Department
Months on Job
Shift
Weekly Wage
County of Injury
Nature of Injury
Body Part
Accident Type
Source of Injury
Date Returned
Time Present Job
Extent of Disability
Lost Workdays
Injury Date
Injury Hour
Date of Disability
Date of Report

EVERY QUESTION MUST BE ANSWERED AND FORM SIGNED

FORM S.F. 1 (REVISED JULY, 1980)
KENTUCKY DEPARTMENT OF LABOR
WORKERS' COMPENSATION BOARD
FRANKFORT, KENTUCKY 40601

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS AND SUPPLEMENTARY RECORD UNDER THE OCCUPATIONAL SAFETY AND HEALTH ACT

IF THIS CASE WAS OSHA RECORDABLE, INDICATE REASON FOR RECORDING AND GIVE OSHA CASE OR FILE NUMBER.

This form fulfills the requirements for OSHA Form 101

KRS 342.990 AUTHORIZES A FINE FOR EMPLOYER'S REFUSAL OR WILLFUL NEGLECT TO SUBMIT THIS ORIGINAL REPORT WITHIN ONE WEEK OF KNOWLEDGE OF INJURY TO THE WORKERS' COMPENSATION BOARD. TO COMPLY WITH THIS LAW, EACH QUESTION SHALL BE ANSWERED COMPLETELY, ACCURATELY AND LEGIBLY. IMPROPERLY PREPARED REPORTS WILL BE REFUSED AND RETURNED PLEASE USE TYPEWRITER OR PRINT IN INK. COMPLETE ALL QUESTIONS!

Reason for recording (e.g. "loss of consciousness")

OSHA Case or File Number (from your OSHA Form 100)

EMPLOYER

1. EMPLOYER'S NAME: Owen County R.E.C.C. — EMPLOYER NUMBER: 61-0299615
2. STREET OR ROAD — LOCATION AT WHICH EMPLOYEE WORKED: 7353 Walton-Nicholson Road
3. IF INDIVIDUAL OR PARTNERSHIP, NAME OF BUSINESS:
4. CITY, COUNTY, STATE, ZIP: Independence, Kenton, KY 41051
5. MAILING ADDRESS: 510 Georgetown Road
6. AREA CODE TELEPHONE: 502-484-3471
7. UNEMPLOYMENT INSURANCE I.D. No. Q12321-6
8. CITY, COUNTY, STATE, ZIP: Owenton, Owen, KY 40359
9. NATURE OF BUSINESS (e.g., tree trimming, boot mfg.): Electric Distribution
10. WORKERS' COMPENSATION INSURANCE CARRIER (IF SELF-INSURED, CHECK HERE ☐) — POLICY NUMBER: PWC-L-11-22-34-00
11. SPECIFIC PRODUCT OR SERVICE COMPRISING MAJORITY OF SALES (e.g., ski boots): Electricity

EMPLOYEE

12. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST): ARGUST NELSON POPHAM
13. AREA CODE TELEPHONE (HOME): 606-485-7621
14. SOCIAL SECURITY NO.: 403-56-3395
15. EMPLOYEE'S HOME ADDRESS: 21 Bendinger Avenue
16. SINGLE ☐ MARRIED ☒ MALE ☒ FEMALE ☐
17. DATE OF BIRTH:
18. CITY, COUNTY, STATE, ZIP: Walton, Boone, Kentucky 41094
19. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Maintenance
20. REGULAR OCCUPATION (JOB TITLE): Journeyman Lineman
21. DEPARTMENT WHERE WORKING WHEN INJURY OR OCCURRED: Maintenance
22. HOW LONG EMPLOYED BY YOU? 20 years
23. HOW LONG IN PRESENT JOB? 3½ years
24. NUMBER OF HOURS WORKED PER DAY 8 PER WK. 40
25. NUMBER OF DAYS WORKED PER WK. 5
26. EMPLOYEE'S WAGE RATE $ 10.80 HR. or $ /DAY, or $ /WK.
27. COMMISSION OR PIECE WORK EARNINGS $ n/a IN HRS. IN PAST 12 MO.
28. WEEKLY DOLLAR VALUE OF PAY IN KIND (LODGING, FOOD, ETC.) $ n/a
29. NO. OF DEPENDENTS (Please complete back of form): 3

THE ACCIDENT OR EXPOSURE

30. PLACE OF ACCIDENT OR EXPOSURE (LOCATION, INCLUDING COUNTY): So. Woods, Richardson Rd. Kenton Co.
31. DATE EMPLOYER NOTIFIED: 7/6/82
32. ON EMPLOYER'S PREMISES? YES ☐ NO ☒
33. DATE OF OCCURRENCE: 7/4/82
34. TIME OF DAY: 5:00pm
35. TIME WORKDAY BEGAN AND WOULD NORMALLY END FROM 8:00 (A.M.) TO 4:30 (P.M.)
36. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)
    Employee was working on underground service outage
37. (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)
    Another serviceman was removing primary elbow from cabinet part of the bar on terminal broke, fell into ground causing an part of the bar with terminals
38. WHAT OBJECT DIRECTLY PRODUCED THE INJURY OR ILLNESS? (Name object struck against or struck by, vapor, poison, chemical, or radiation. If strain or hernia, the thing being lifted, pulled, pushed, etc. If injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)
    explosion and flash of fire, causing blurred vision on Nelson P.

THE INJURY OR ILLNESS

39. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF BODY AFFECTED. (e.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)
    Singed eyelashes
    Blurred vision for 24 hrs. of both eyes
    FATAL? YES ☐ NO ☒
40. NAME AND ADDRESS OF TREATING PHYSICIAN: n/a (unless further problem occures)
41. NAME AND ADDRESS OF HOSPITAL: n/a — IN PATIENT ☐ OUT PATIENT ☐
42. MEDICAL TREATMENT GIVEN (DESCRIBE) — IF RESTRICTIONS OF DUTY OR PERMANENT TRANSFER TO ANOTHER JOB, CHECK ☐
    First aid-kit eye ointment applied by employee
43. DATE STOPPED WORK BECAUSE OF THIS INJURY OR ILLNESS: n/a
44. DATE RETURNED TO WORK: n/a
45. NUMBER OF SCHEDULED WORK DAYS LOST TO DATE: n/a
46. WAS EMPLOYEE PAID FOR FULL DAY ON DATE OF INJURY? YES ☒ NO ☐
47. IF DEATH, GIVE NAME AND ADDRESS OF NEXT OF KIN: n/a
48. DATE OF DEATH: n/a
49. REPORT PREPARED BY: [signature]
50. TITLE: [signature]
51. DATE OF THIS REPORT: 7-19-82

DO NOT WRITE IN THIS COLUMN: File No. / Employer No. / U.I. No. / Industry / Soc. Sec. No. / Age / Sex / Marital Status / Occupation / Department / Months on Job / Shift / Weekly Wage / County of Injury / Nature of Injury / Body Part / Accident Type / Source of Injury / Date Returned / Time Present Job / Extent of Disability / Lost Workdays / Injury Date / Injury Hour / Date of Disability / Date of Report

EVERY QUESTION

PPLEMENTARY RECORD UNDER
E OCCUPATIONAL SAFETY
D HEALTH ACT

WORKERS' COMPENSATION BOARD
Frankfort, Kentucky 40601

IF THIS CASE WAS OSHA RECORDABLE, INDICATE REASON FOR RECORDING AND GIVE OSHA CASE OR FILE NUMBER.

days off; prescription drugs
Reason for recording (e.g. "loss of consciousness")

2/91
OSHA Case or File Number (from your OSHA Form 200)

his form fulfills the requirements for OSHA Form 101

KRS 342.990 AUTHORIZES A FINE FOR EMPLOYER'S REFUSAL OR WILLFUL NEGLECT TO SUBMIT THIS ORIGINAL REPORT WITHIN ONE WEEK OF KNOWLEDGE OF INJURY TO THE WORKERS' COMPENSATION BOARD. TO COMPLY WITH THIS LAW, EACH QUESTION SHALL BE ANSWERED COMPLETELY, ACCURATELY AND LEGIBLY. IMPROPERLY PREPARED REPORTS WILL BE REFUSED AND RETURNED PLEASE USE TYPEWRITER OR PRINT IN INK COMPLETE ALL QUESTIONS!

EMPLOYER

1. EMPLOYER'S NAME: Owen County R.E.C.C. — EMPLOYER NUMBER: 61-0299615
2. STREET OR ROAD LOCATION AT WHICH EMPLOYEE WORKED: 510 Georgetown Road
3. IF INDIVIDUAL OR PARTNERSHIP, NAME OF BUSINESS:
4. CITY COUNTY STATE ZIP: Owenton, Owen, Kentucky 40359
5. MAILING ADDRESS: 510 Georgetown Road
6. AREA CODE TELEPHONE: 502-484-3471
7. UNEMPLOYMENT INSURANCE I.D. No.: 012321-6
8. CITY COUNTY STATE ZIP: Owenton, Owen, Kentucky 40359
9. NATURE OF BUSINESS (e.g., tree trimming, boot mfg.): Distribution of electricity
10. WORKERS' COMPENSATION INSURANCE CARRIER (IF SELF-INSURED, CHECK HERE ☐) POLICY NUMBER: 16-WC-005
11. SPECIFIC PRODUCT OR SERVICE COMPRISING MAJORITY OF SALES (e.g., ski boots): electricity

EMPLOYEE

12. EMPLOYEE'S NAME FIRST MIDDLE LAST: Argust Nelson Popham
13. AREA CODE TELEPHONE (HOME): 606-586-6864
14. SOCIAL SECURITY NO.: 403-56-3395
15. EMPLOYEE'S HOME ADDRESS: 9540 Lower River Road
16. SINGLE ☐ MARRIED ☒ MALE ☒ FEMALE ☐
17. DATE OF BIRTH: 2-1-40
18. CITY COUNTY STATE ZIP: Burlington, Boone, Kentucky 41005
19. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Maintenance
20. REGULAR OCCUPATION (JOB TITLE): Serviceman
21. DEPARTMENT WHERE WORKING WHEN INJURY OR OCCURRED: Maintenance
22. HOW LONG EMPLOYED BY YOU?: 21 yrs, 10 months
23. HOW LONG IN PRESENT JOB?: 12 years
24. NUMBER OF HOURS WORKED PER DAY: 8 PER WK.: 40
25. NUMBER OF DAYS WORKED PER WK.: 5
26. EMPLOYEE'S WAGE RATE $ 16.33 HR. or $ /DAY, or $ /WK.
27. COMMISSION OR PIECE WORK EARNINGS $ n/a IN HRS. IN PAST 12 MO.
28. WEEKLY DOLLAR VALUE OF PAY IN KIND (LODGING, FOOD, ETC.) $ n/a
29. NO. OF DEPENDENTS: 1 (Please complete back of form)
30. PLACE OF ACCIDENT OR EXPOSURE (LOCATION, INCLUDING COUNTY): Mt. Zion Rd, Boone County, KY
31. DATE EMPLOYER NOTIFIED: 2-1-91
32. ON EMPLOYER'S PREMISES? YES ☐ NO ☒
33. DATE OF OCCURRENCE: 1-31-91
34. TIME OF DAY: 2 PM
35. TIME WORKDAY BEGAN AND WOULD NORMALLY END FROM (A.M.) (P.M.) 8 AM TO (A.M.) (P.M.) 4:30 PM

36. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)
Stooped over to connect an underground service

37. (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)
When he straightened up, back pain occurred

38. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by, vapor, poison, chemical, or radiation. If strain or hernia, the thing being lifted, pulled, pushed, etc. If injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)
Working in a stooped position for an extended length of time

39. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF BODY AFFECTED. (e.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)
Lower back strain - pain
FATAL? YES ☐ NO ☒

40. NAME AND ADDRESS OF TREATING PHYSICIAN
Richard Hoblitzell, Orthopaedic Care of Greater Cincinnati
7570 U.S. Highway 42, Florence, KY 40142 Phone 606-371-4442

41. NAME AND ADDRESS OF HOSPITAL
IN PATIENT ☐ OUT PATIENT ☐

42. MEDICAL TREATMENT GIVEN (DESCRIBE) IF RESTRICTIONS OF DUTY OR PERMANENT TRANSFER TO ANOTHER JOB, CHECK ☐
Prescribed pain medication, muscle relaxers, and physical therapy

43. DATE STOPPED WORK BECAUSE OF THIS INJURY OR ILLNESS: 2-1-91
44. DATE RETURNED TO WORK: 2-5 and then off again 2-6; back 2-7
45. NUMBER OF SCHEDULED WORK DAYS LOST TO DATE: 4
46. WAS EMPLOYEE PAID FOR FULL DAY ON DATE OF INJURY? YES ☒ NO ☐

47. IF DEATH, GIVE NAME AND ADDRESS OF NEXT OF KIN: n/a
48. DATE OF DEATH: n/a

49. REPORT PREPARED BY: Donna McDonald
50. TITLE: Exec. Sec/Claims
51. DATE OF THIS REPORT: 2-7-91

*Popham was scheduled to work Saturday, Feb. 2nd but was unable

EVERY QUESTION MUST BE ANSWERED AND FORM SIGNED

DO NOT WRITE IN THIS COLUMN
File No.
Employer No.
U.I. No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Department
Months on Job
Shift
Weekly Wage
County of Injury
Nature of Injury
Body Part
Accident Type
Source of Injury
Date Returned
Time Present Job
Extent of Disability
Lost Workdays
Injury Date
Injury Hour
Date of Disability
Date of Report

FORM S.F. 1 (REVISED JULY, 1980)
KENTUCKY DEPARTMENT OF LABOR
WORKERS' COMPENSATION BOARD
FRANKFORT, KENTUCKY 40601

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS AND SUPPLEMENTARY RECORD UNDER THE OCCUPATIONAL SAFETY AND HEALTH ACT

IF THIS CASE WAS OSHA RECORDABLE, INDICATE REASON FOR RECORDING AND GIVE OSHA CASE OR FILE NUMBER.

This form fulfills the requirements for OSHA Form 101

1 *Reason for recording (e.g. "loss of consciousness")*

OSHA Case or File Number (from your OSHA Form 200)

KRS 342.990 AUTHORIZES A FINE FOR EMPLOYER'S REFUSAL OR WILLFUL NEGLECT TO SUBMIT THIS ORIGINAL REPORT WITHIN ONE WEEK OF KNOWLEDGE OF INJURY TO THE WORKERS' COMPENSATION BOARD. TO COMPLY WITH THIS LAW, EACH QUESTION SHALL BE ANSWERED COMPLETELY, ACCURATELY AND LEGIBLY. IMPROPERLY PREPARED REPORTS WILL BE REFUSED AND RETURNED. PLEASE USE TYPEWRITER OR PRINT IN INK. COMPLETE ALL QUESTIONS!

EMPLOYER

1. EMPLOYER'S NAME — EMPLOYER NUMBER: OWEN ELECTRIC COOPERATIVE 61-0299615
2. STREET OR ROAD LOCATION AT WHICH EMPLOYEE WORKED: 510 South Main Street
3. IF INDIVIDUAL OR PARTNERSHIP, NAME OF BUSINESS:
4. CITY: Owenton — COUNTY: Owen — STATE: KY — ZIP: 40359
5. MAILING ADDRESS: 510 South Main Street
6. AREA CODE TELEPHONE: 502-484-3471
7. UNEMPLOYMENT INSURANCE I.D. NO.: 012321-6
8. CITY: Owenton — COUNTY: Owen — STATE: KY — ZIP: 40359
9. NATURE OF BUSINESS (e.g., tree trimming, boot mfg.): Electric Distribution
10. WORKERS' COMPENSATION INSURANCE CARRIER — POLICY NUMBER (IF SELF-INSURED, CHECK HERE ☐): 16 WC 005
11. SPECIFIC PRODUCT OR SERVICE COMPRISING MAJORITY OF SALES (e.g., ski boots): Electricity

EMPLOYEE

12. EMPLOYEE'S NAME — FIRST — MIDDLE — LAST: Nelson Popham
13. AREA CODE TELEPHONE (HOME): 606-586-6864
14. SOCIAL SECURITY NO.: 403-56-3395
15. EMPLOYEE'S HOME ADDRESS: 9540 Lower River Rd
16. SINGLE ☐ MARRIED ☒ — MALE ☒ FEMALE ☐
17. DATE OF BIRTH: 2-1-40
18. CITY: Burlington — COUNTY: Boone, — STATE: KY — ZIP: 41005
19. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Maintenance
20. REGULAR OCCUPATION (JOB TITLE): Serviceman
21. DEPARTMENT WHERE WORKING WHEN INJURY OR OCCURRED: Same
22. HOW LONG EMPLOYED BY YOU?: 25 yrs.
23. HOW LONG IN PRESENT JOB?: 15 years
24. NUMBER OF HOURS WORKED — PER DAY: 8 — PER WK.: 40
25. NUMBER OF DAYS WORKED PER WK.: 5
26. EMPLOYEE'S WAGE RATE $: 18.28 HR. or $ /DAY, or $ /WK.
27. COMMISSION OR PIECE WORK EARNINGS $: n/a IN HRS. IN PAST 12 MO.
28. WEEKLY DOLLAR VALUE OF PAY IN KIND (LODGING, FOOD, ETC.) $: n/a
29. NO. OF DEPENDENTS: 1 (Please complete back of form)
30. PLACE OF ACCIDENT OR EXPOSURE (LOCATION, INCLUDING COUNTY): Daniels Lane, Beech Grove Rd, Boone Co
31. DATE EMPLOYER NOTIFIED: 8/5/94

THE ACCIDENT OR EXPOSURE

32. ON EMPLOYER'S PREMISES? YES ☐ NO ☒
33. DATE OF OCCURRENCE: 8/5/94
34. TIME OF DAY: 5:00 AM
35. TIME WORKDAY BEGAN AND WOULD NORMALLY END — FROM 8AM (A.M.) (P.M.) TO 4:30 PM (A.M.) (P.M.)
36. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.): Climbing Pole - Kicked out - slid and fell down pole
37. (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.): Climbing Hooks caught in ground wire on pole
38. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by, vapor, poison, chemical, or radiation. If strain or hernia, the thing being lifted, pulled, pushed, etc. If injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.): Hooks catching in ground wire

THE INJURY OR ILLNESS

39. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF BODY AFFECTED. (e.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.): Arms skinned, knee, ankle and back sore — FATAL? YES ☐ NO ☒
40. NAME AND ADDRESS OF TREATING PHYSICIAN: Already had appt. scheduled for something else-will get checked over. Burlington Med. Ctr, Burlington KY
41. NAME AND ADDRESS OF HOSPITAL — IN PATIENT ☐ OUT PATIENT ☐
42. MEDICAL TREATMENT GIVEN (DESCRIBE) — IF RESTRICTIONS OF DUTY OR PERMANENT TRANSFER TO ANOTHER JOB, CHECK ☐
43. DATE STOPPED WORK BECAUSE OF THIS INJURY OR ILLNESS: n/a
44. DATE RETURNED TO WORK: n/a
45. NUMBER OF SCHEDULED WORK DAYS LOST TO DATE: n/a
46. WAS EMPLOYEE PAID FOR FULL DAY ON DATE OF INJURY? YES ☒ NO ☐
47. IF DEATH, GIVE NAME AND ADDRESS OF NEXT OF KIN: n/a
48. DATE OF DEATH: n/a
49. REPORT PREPARED BY: Donna McDonald
50. TITLE: Exec. Secretary
51. DATE OF THIS REPORT: 8/5/94

DO NOT WRITE IN THIS COLUMN: File No. — Employer No. — U.I. No. — Industry — Soc. Sec. No. — Age — Sex — Marital Status — Occupation — Department — Months on Job — Shift — Weekly Wage — County of Injury — Nature of Injury — Body Part — Accident Type — Source of Injury — Date Returned — Time Present Job — Extent of Disability — Lost Workdays — Injury Date — Injury Hour — Date of Disability — Date of Report

EVERY QUESTION MUST BE ANSWERED AND FORM SIGNED

Ref # N049 226

. 1 (REV. MAY, 1994)
IPLOYER'S FIRST REPORT
INJURY OR ILLNESS AND
PPLEMENTARY RECORD UNDER
E OCCUPATIONAL SAFETY
:D HEALTH ACT

DEPARTMENT OF WORKERS' CLAIMS
1270 Louisville Road
Perimeter Park West, Building C
Frankfort, Kentucky 40601

IF THIS CASE WAS OSHA RECORDABLE, INDICATE REASON FOR RECORDING AND GIVE OSHA CASE OR FILE NUMBER.

Days off
Reason for recording (e.g. "loss of consciousness")

02/95
OSHA Case or File Number (from your OSHA Form 200)

RS 342.990 AUTHORIZES A FINE FOR EMPLOYER'S FAILURE TO SUBMIT THIS ORIGINAL REPORT ITHIN ONE WEEK OF KNOWLEDGE OF INJURY TO THE DEPARTMENT OF WORKERS' CLAIMS WITH COPY TO YOUR INSURANCE CARRIER OR OTHER BENEFIT PAYOR. TO COMPLY WITH THIS LAW, EACH UESTION SHALL BE ANSWERED COMPLETELY, ACCURATELY AND LEGIBLY. IMPROPERLY PREPARED EPORTS WILL BE REFUSED AND RETURNED. PLEASE USE TYPEWRITER OR PRINT IN INK. COMPLETE LL QUESTIONS!

EMPLOYER

1. EMPLOYER'S NAME: Owen Electric Cooperative — EMPLOYER NUMBER: 61-0299615
2. STREET OR ROAD LOCATION AT WHICH EMPLOYEE WORKED: 510 South Main Street
3. IF INDIVIDUAL OR PARTNERSHIP, NAME OF BUSINESS:
4. CITY: Owenton — COUNTY: Owen — STATE: Ky — ZIP: 40359
5. MAILING ADDRESS: 510 South Main Street
6. AREA CODE TELEPHONE: 502-484-3471
7. UNEMPLOYMENT INSURANCE I.D. No.: 012321-6
8. CITY: Owenton — COUNTY: Owen — STATE: Ky — ZIP: 40359
9. NATURE OF BUSINESS (e.g., tree trimming, boot mfg.): Electric Distribution
10. WORKERS'S COMPENSATION INSURANCE CARRIER (IF SELF-INSURED, CHECK HERE ☐): — POLICY NUMBER:
11. SPECIFY PRODUCT OR SERVICE COMPRISING MAJORITY OF SALES (e.g., ski boots): Electricity

EMPLOYEE

12. EMPLOYEE'S NAME — FIRST: Argust — MIDDLE: Nelson — LAST: Popham
13. AREA CODE TELEPHONE (HOME): 606-586-6864
14. SOCIAL SECURITY NO.: 403-56-3395
15. EMPLOYEE'S HOME ADDRESS: 9540 Lower River Road
16. SINGLE ☐ MARRIED ☒ — MALE ☒ FEMALE ☐
17. DATE OF BIRTH: 2-1-40
18. CITY: Burlington — STATE: KY — ZIP: 41005
19. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Maint/ Service
20. REGULAR OCCUPATION (JOB TITLE): Serviceman
21. DEPARTMENT WHERE WORKING WHEN INJURY OCCURRED: Same
22. HOW LONG EMPLOYED BY YOU?: 26 years
23. HOW LONG IN PRESENT JOB?: 15 years
24. NUMBER OF HOURS WORKED — PER DAY: 8 — PER WK.: 40
25. NUMBER OF DAYS WORKED PER WK.: 5
26. EMPLOYEE'S WAGE RATE $: 18.92/HR. or $ /DAY, or $ /WK.
27. COMMISSION OR PIECE WORK EARNINGS $: n/a IN HRS. IN PAST 12 MO.
28. WEEKLY DOLLAR VALUE OF PAY IN KIND (LODGING, FOOD, ETC.)$: n/a
29. NO. OF DEPENDENTS (Please complete back of form): 1
30. PLACE OF ACCIDENT OR EXPOSURE (LOCATION, INCLUDING COUNTY): East Bend Road, Burlington, Boone Co, KY
31. DATE EMPLOYER NOTIFIED: 4-8-95

THE ACCIDENT OR EXPOSURE

32. ON EMPLOYER'S PREMISES? YES ☐ NO ☒
33. DATE OF OCCURENCE: 4-8-95
34. TIME OF DAY: 2:30 PM
35. TIME WORKDAY BEGAN AND WOULD NORMALLY END FROM (A.M.) 8AM (A.M.) (P.M.) 4:30 PM (P.M.)
36. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure? Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)
Repairing service
37. (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)
Climbed into bed of truck for material, stepped down off tailgate onto right foot
38. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name objects struck against or struck by; vapor, poison, chemical, or radiation. If strain or hernia, the thing being lifted, pulled, pushed, etc. If injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)
Weight on right foot

THE INJURY OR ILLNESS

39. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF BODY AFFECTED. (e.g. amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)
injured tendon - right foot
FATAL? YES ☐ NO ☒
40. NAME AND ADDRESS OF TREATING PHYSICIAN: Dr. Elizabeth Woolford, 1983 Florence Pk, Burlington KY 41005
41. NAME AND ADDRESS OF HOSPITAL:
IN PATIENT ☐ OUT PATIENT ☐
42. MEDICAL TREATMENT GIVEN (DESCRIBE): ex-ray; wrapped foot; medication for pain
IF RESTRICTIONS OF DUTY OR PERMANENT TRANSFER TO ANOTHER JOB, CHECK ☐
43. DATE STOPPED WORK BECAUSE OF THIS INJURY OR ILLNESS: 4-11-95
44. DATE RETURNED TO WORK: has not
45. NUMBER OF SCHEDULED WORK DAYS LOST TO DATE: 2
46. WAS EMPLOYEE PAID FOR FULL DAY ON DATE OF INJURY? YES ☒ NO ☐
47. IF DEATH, GIVE NAME AND ADDRESS OF NEXT OF KIN: n/a
48. DATE OF DEATH: n/a
49. REPORT PREPARED BY: Donna McDonald
50. TITLE: Executive Secretary/personnel
51. DATE OF THIS REPORT: 4-12-95

DO NOT WRITE IN THIS COLUMN

File No.
Employer No.
U.I. No.
Industry
Soc. Sec. No.
Age
Sex
Marital Status
Occupation
Department
Months on Job
Shift
Weekly Wage
County of Injury
Nature of Injury
Body Part
Accident Type
Source of Injury
Date Returned
Time Present Job
Extent of Disability
Lost Workdays
Injury Date
Injury Hour
Date of Disability
Date of Report

OWEN ELECTRIC COOPERATIVE

510 South Main Street • Owenton, Kentucky 40359 • 502/484-3471

SO NO 131415 DIST 11

REQ BY RODNEY

TAKEN BY MARY ELLEN 03/13/96

APL. NO 09:24

SC MISCELLANEOUS MAINT. WORK ON 03/13/96 OWEN PRINTED ** 01 ** TIMES

EPHENSON RICKEY L
LLY BELINDA J
04 STEPHENSON MILL RD
LTON KY
41094-9575
NPUBLISHED PHONE

MBRSEP 34943-01
SS NO 405-82-1912
S-SS NO
TEL 6064857827
B PHONE
DRV LIC
S BUS NO

CYC 99 RATE 1 TAX CD N
TDC 61 CLASS 30 ASST N
DST OWEN PRI BUD
COU 6 NEWS Y AMT
CTY PEN N DTE
BCD 4 CUT N SVC
NEB MAIL Y MIN

FEES — DEPOSITS / CHARGES

	BILL	APPLY	PD	PAST		CD	CHARGE
E					MISC		
P					OTH		
H							

LOCATION DATA

C	61362073293 CYC 308	SUB 4	UG	STEPHENSON RICKEY L	
Q	308000027500	CIR 6	HC	C-DTE 12/13/91	
C	1304 STEPHENSON MILL RD	BKR	AC	D-DTE 08/25/94	
E		PHA 1	MH 1	SO REF	
D	R LANE WHITE TRAILER MP	HP	SW		
A	61362074263		LS	6018	TEN

SECURITY LIGHT DATA

	CONSUMER RATE	TY	NO	KWH	AMOUNT		LOCATION RATE	TY	NO	KWH	AMOUNT
	1	1	1			1)	1	1	1		
						2)					
						3)					
						4)					

ATIO: 01 TY: MS

METER DATA

RDG 02675

	DATE	COOP NO	VOLTS	AMP	WIRE	MUL	DI	DM	IC	READ	DEMAND
IT		51527 MFG: 5 PH: 1	240	30.0	3	1	5		1	02675	

RY ELLEN WED. MAR 13. 1996. 9:23 AM

TER D/C 8/94. PLEASE REMOVE METER. INSTALL COVER. D/C AT TRANSF. POSSIBLE.

Step meter 01.

Di, nt To Stock

NED-SERVICEMAN AMP DATE WORKED 3-25-96 PROCESSED BY

V SERVICE ROUTING Construction Engineering Drafting Loc. File

MON, MAR 25, 1996, 3:04 PM PRINTED FROM TERMINAL # 150

GENERAL CONSUMER INQUIRY

3494301 DIST 14 CYCL 99
STEPHENSON RICKEY L
KELLY BELINDA J
1304 STEPHENSON MILL RD
WALTON KY
4109495?5
SPOUSE NONPUBLISHED PHONE

STATUS I U LD MGT 0
LOCTN 61362073293
RDG SEQN 308000027500
METER NBR 51527
TELEPHONE 6064857627
DRV LIC
SOC SEC NBR 405821912
HP RMG

APPLDATE 61687 DRAFT
CONNDATE 121391
DISCDATE 82594
DELQ 13 BDCK 0 MBRSE
CUTF 11 ACUT 1 CD 1
EST 0 VAC 0 2
KVAMIN .00 3
MINAMT .00 4

NOTE
POLE

DEMAND 0 DEM MULT
MTR MULT 1 MTR DIALS

RATE	1	COUNTY	6	MAIL CD	0	TAX CD	0	PEN CD	0	XREF	
CLASS	30	CITY	0	NEWS CD	0	TAXDST	61	CUT CD	0	ASST	0 STCD 1
PS CD	0	NAT CD	1	X BIL	0	DUN CD	2	ENERGY	0	PAT	.00

RT	TY	NO	KWH	AMOUNT	REOCCURRING CD	REOCCURRING AMOUNT	CONSUMER	BUDGET	ACCOUNT
1	1	1					CD 1:		BALANCE
					1		2:	AMT	.00
					2		3:	BAL	LAST BILL
					3		4:	CD	090894

DEPRESS FUNCTION KEY FROM THE LIST BELOW

Attachment C

Photographs